

Name: _____

License No/Application ID: _____

FINANCIAL RESPONSIBILITY
Advanced Registered Nurse Practitioners

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only **ONE** option that best describes your situation. If you provided financial responsibility information to a hospital or elsewhere, please be consistent when choosing an option below.

Please be advised, failing to choose an option or choosing more than one option will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding choosing an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

- ☐ 1. I have obtained and will maintain Professional liability coverage of at least \$100,000 per claim with a minimum annual aggregate of at least \$300,000 from an authorized insurer under Section 624.09, F.S., a surplus lines insurer under Section 626.914(2), F.S., a joint underwriting association under Section 627.351(4), F.S., a self-insurance plan under Section 627.357, F.S., or a risk retention group under Section 627.942, F.S.
- ☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined by Chapter 675, F.S. which is in the amount of at least \$100,000 per claim with a minimum aggregate availability of at least \$300,000 and which is payable to the ARNP as beneficiary.

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

- ☐ 1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
- ☐ 2. My Florida license is inactive and I do not practice in the State of Florida.
- ☐ 3. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.
- ☐ 4. My Florida license is active, but I do not practice in the State of Florida.
- ☐ 5. I have had no malpractice exposure in the state and can demonstrate to the board or department my lack of malpractice exposure.
- ☐ 6. I have just completed my Advanced Registered Nurse Practitioner Program and/or I am not yet practicing in Florida.

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action or criminal penalties as provided in Sections 456.067, 456.072, Florida Statutes.

Signature of Licensee

Date